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| F 000 | INITIAL COMMENTS<br><br>An annual survey and complaint visit was conducted at the facility from February 23, 2010 through March 4, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included forty (40) admission and thirty (30) census residents in Stage I. The Stage II sample included thirty-three (33) residents. | F 000 | **F225:**<br>Complaint reported to Administrator during survey on March 1, 2010 and investigation re-opened as alleged abuse. E16 placed on administrative leave, protecting R105, during the investigation. Reporting and investigation procedures followed. (Attachment F225: 1 and 2) | 3/18/10 |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the | F 225 | All residents have the potential to be affected and the following corrective actions are being taken:<br>Staff (all) re-education on abuse, neglect, mistreatment, and misappropriation (Attachment F225: 3) beginning 3/30/2010.<br>Staff (all) re-education on resident complaints and accountability to immediately report to Administrator with signed "Memorandum of Accountability" documented to personnel records (Attachment F225: 4) beginning 4/5/2010.<br><br>Daily review of resident complaints documented on Incident Report (Attachment F225: 5) forms will be reviewed by Resident Protection Committee (Attachment F225: 6) to ensure that complaints are defined properly to discern potential allegations | 4/13/10<br><br>4/1/10 |

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mindy L. Mead, NHA | Administrator | 4/20/10

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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| F 225 | Continued From page 1<br>investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and review of other facility documentation it was determined that for one (R105) out of 33 sampled residents the facility failed to report an allegation of abuse to the state agency (Division of Long Term Care Residents Protection, DLTCRP) and failed to protect the resident and prevent further potential abuse while the investigation is in progress. Findings include:<br><br>1. Interview with R105 on 3/1/10 and review of a facility reportable event form dated 2/16/10 documented that the resident (R105) alleged that on 2/13/10 while aide E16 was getting her ready for bed by transferring her in the sit to stand lift the strap was around her arm instead of under her arm. The resident alleges she asked E16 what she was going to do. R105 alleged that E16 said "we will just have to cut your arm off". R105 had an amputation to her left leg and paralysis to the left side of her body from a stroke.<br><br>R105 revealed that she did not immediately report the incident but waited and talked to the charge nurse E13 on 2/16/10. The charge nurse E13 | F 225 | **F225-continued**<br>of abuse, neglect, mistreatment, and misappropriation.<br>Investigations of abuse, neglect, mistreatment, misappropriation will determine other staff knowledge of complaint. Reasonably substantiated variances in staff accountability will result in corrective action as outlined in the "Memorandum of Accountability".<br><br>Audits of Resident Protection Committee review of complaints initiated 4/1/2010 with corrective action taken for variances (Attachment F225: 7).<br>Results of the audit will be submitted to Administrator and Facility Operations Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/15/10 |

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| F 225 | Continued From page 2<br>completed an incident report and collected staff statements on 2/16/10. E16 denies the allegation and there had been no identified witnesses. Interview with the DON, E2 revealed that this incident was treated as a grievance/concern not as an allegation of abuse.<br><br>A statement provided by aide E17 revealed that on 2/14/10 he assumed R105's care part way through the shift and the resident verbalized the above incident to him. There was no evidence that E17 reported this to his supervisor or any other facility staff.<br><br>The facility's procedure "Abuse - Definitions & Investigation" defines emotional abuse as "which includes but is not limited to ridiculing or demeaning a patient or resident, making derogatory remarks to a patient or resident or cursing directed towards a patient or resident. or threatening to inflict physical emotional harm on a patient or resident". The policy stated that the facility will protect and promote safety of the resident during any alleged abuse investigation. From 2/16/10 until 3/1/10 E16 continued to care for R105.<br><br>The policy also indicated that allegations of abuse were reportable to the state agency (DLTCRP). The facility did not report this allegation to the state agency and failed to protect the resident. | F 225 | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. | F 241 | **F241:**<br>No known or identifiable resident to be found to have been affected resulting by this deficient practice. | |

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| F 241 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations it was determined that the facility failed to ensure the care was provided in a manner that enhanced resident dignity. Findings include:<br><br>1. General dining observation on 2/23/10 at 12:34 PM revealed aide E19 feeding resident (SS#1) lunch wearing gloves. There was no indication for the use of gloves. The aide was not touching the residents food.<br><br>2. On 2/26/10 at 12:30 PM dining was observed in the 1st floor main dining room. Activity staff E20 was observed walking around talking to residents with gloves on. There was no indication for the use of gloves.<br><br>3. Cross refer F441.<br>R167 was observed on 2/24/10 at approximately 10:35 AM wearing personal protective equipment including gown and gloves and being transported by therapy department staff (E9) who had on both gown and gloves. Subsequent observation of R167 on 3/1/10 at approximately 11:15 PM revealed R167 being transported in a wheelchair by E9 who had gloves on. Review of R167's March 2010 Physician's Order Sheet noted an order for contact precaution.<br><br>Review of facility's policy titled "Contact Precautions Protocol" indicated for transporting resident, "immediately before leaving room with the resident, remove gown and gloves at doorway and discard in trash can. Clean hands."<br><br>Interview with the Program Director of Therapy | F 241 | **F241 continued:**<br>All residents have the potential to be affected by the same deficient practice. Staff (all) re-education regarding proper gloving and resident dignity will begin by 3/31/2010 (Attachment F241: 1)<br><br>Audits for gloving and resident dignity will be conducted daily (Attachment F241: 2 ), beginning 3/30/2010.<br><br>Results of the audit will be submitted to Administrator and Resident Experience Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/13/10<br><br>4/13/10<br><br>4/13/10 |

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| F 241 | Continued From page 4<br>(E10) on 3/3/10 at approximately 2 PM confirmed that the above policy was not followed by the facility staff, thus, failed to treat the resident in a manner that enhanced resident's dignity. | F 241 | **F248:**<br>Resident #78 was reassessed on 3/29/2010 and care plan updated on 3/29/2010 that reflects individualized interests, strengths, and current abilities. As a result of the assessment, the care plan was updated and changed to reflect goals for participation and engagement in activities to include, "Resident will respond to the program's topic of conversation for 10-15 minutes during reminisce programs, 2-3 times per week by re-evaluation date" and "Resident will follow the activity program's content, AEB eye tracking, facial grimace, during sensory activities, 1:1 (one-to-one)-2-3 times per week by re-evaluation date". The individualized approaches for resident #78 are: 1. Invite to group activities early to allow Resident time to express feelings about family, loss of roles; 2. Show Resident understanding if crying out occurs; 3. Provide 1:1 activities of stated interest, e.g., talk about fire department, hunting, baseball, fishing; 4. Compliment Resident on activity participation; 5. Respect Resident's right to refuse activities.<br>(Attachment F248: 1, 2, 3) | 3/29/10 |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview and record review, it was determined that for 2 out of 33 residents (R78 and R22), the facility failed to provide an ongoing program of activities to meet the needs and interests of each resident.<br>Findings include:<br><br>1. According to the annual MDS (minimum data set), dated 01/14/10, R#78 was a totally dependent, wheel chair-bound resident, who could communicate preferences for activities. This resident was observed, on 02/26/10 and 03/01/10 through 03/04/10, to be wheeled to the dining room for meals, afterward, returned to his room to watch television or sleep. No other activities were observed for this resident. When interviewed, this resident expressed interest in at least two scheduled activities, bingo and crafts. This resident was not taken to either of those activities. Activities assessment from 11/12/08 and 01/20/10 revealed that the resident enjoyed music and entertainment. The MDS indicated a preference for music. Interview with E11 of the | F 248 | Resident #22 was reassessed on 2/24/2010 and 3/29/2010 and care plan updated on 3/29/2010 that reflects individualized interests, strengths, and | 3/29/10 |

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| F 248 | Continued From page 5<br>management team, on 03/03/10 at 12:50 PM, indicated that the activities staff assigned to the area were newly hired and still orienting.<br><br>2. According to the quarterly MDS, dated 02/17/10, R#22 was a totally dependent, gerry chair-bound resident, who could not communicate preferences for activities. This resident was observed, on 02/26/10 and 03/01/10 through 03/04/10, to be wheeled to the private dining room for meals, afterward, returned to her room. Family interview on 03/ 03/10 indicated that she enjoyed music in the past. Activities assessment from 09/07/08 and 08/23/09 indicated a preference for music and entertainment. The annual MDS, dated 08/19/10, indicated preferences for music, spiritual/ religious activities, and talking/conversation. Two music activities were observed during the survey and the resident attended neither. Interview with E11 of the management team, on 03/03/10 at 12:50 PM, indicated that the activities staff assigned to the area were newly hired and still orienting. | F 248 | **F248 continued:**<br>current abilities. As a result of the assessment, the care plan was updated and changed to reflect goals for participation and engagement in activities to include, "Resident will attend specialized, smaller group activities for a 15 minute duration, 2-3 times per week by re-evaluation date"; "Resident will respond to activity visits within the setting of the Resident's assessed preference, 2-3 times per week by re-evaluation date"; and "Resident will participate without signs/symptoms of increased anxiety in music-related activities, 2-3 times monthly, according to Monthly Activity Calendar posting by re-evaluation date.<br>The individualized approaches for resident #22 are: 1. Approach Resident to offer group activities when Resident appears relaxed.; 2. Promote participation in activities similar to Resident's past enjoyments such as Country Music, Big Band Music, outdoor activities (sensory for flowers, gardening).; 3. Observe Resident for signs and symptoms of escalating tension/anxiety/over-stimulation.; 4. Offer activity visits in Resident's own room, near Nurse's Workstation.; 5. Review "Looking at the Person", to assess additional potential interest.; 6. Compliment Resident's positive | |
| F 278 SS=B | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | F 278 | | |

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| F 278 | Continued From page 6<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS) assessments for three (R14, R96 and R99) out of 33 sampled residents. Findings include:<br><br>1. Review of R96's annual MDS assessment dated 11/2/09 indicated a current diagnosis of dehydration. Record review lacked evidence of dehydration for the review period. Interview with the Registered Nurse Assessment Coordinator (E14) on 3/3/10 at approximately 9:45 AM revealed that R96 had a history of dehydration, thus, this was coded on the MDS. Interview with the Director of Nursing (E2) on 3/3/10 at approximately 11:50 AM confirmed inaccurate coding of dehydration.<br><br>2. Review of R99's admission "Skin Care Evaluation and Treatment Record" dated 10/2/09 documented a pressure ulcer of the coccyx that | F 278 | **F248 continued:**<br>participation and responses.; 7. Keep a conscientious balance between resident's need for both stimulation and relaxation. (Attachment F248: 4,5,6)<br><br>All residents have the potential to be affected by the same deficient practice with the following corrective actions taken:<br>Activity staff education on 3/23/2010 regarding resident participation in meaningful activities based on assessed interests of the resident (Attachment F248: 7).<br>Consultant provided education specific to F248 on 4/1/2010 (Attachment F248: 8).<br><br>Implementation of enhanced Resident Activity Assessment (Attachment F248: 9) and Program Attendance Record (Attachment F248: 10) to facilitate the tracking of participation and coordinate the facilitation of increased participation based on the changing interests of the resident population and provide outcome based measurements, beginning 4/5/2010.<br><br>Audits of participation levels and congruency to resident-centered interests will be conducted on a weekly basis beginning 4/1/2010 (Attachment F248: 11). | 4/1/10<br><br>4/15/10<br><br>4/15/10 |

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| F 278 | Continued From page 7<br>was unstageable due to the presence of slough (color of wound noted to be tan). Although R99 had one unstageable pressure ulcer as noted on the above record, review of R99's admission MDS assessment dated 10/12/09 failed to code this in Sections M1 and M2. Interview with E14 on 3/1/10 at approximately 12:30 PM confirmed omission in coding and the above description of the skin impairment should have been coded as a stage IV pressure ulcer on the MDS.<br><br>3. R14 had MDSs dated 11/6/09 and 2/17/10 that indicated he was on a "any scheduled toileting plan". An interview with nurses E3 and E21 revealed that the resident was not on a toileting plan because he knew when he had to go to the bathroom and called staff for assistance. | F 278 | **F248 continued:**<br>Results of the audit will be submitted to Administrator and Resident Experience Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame.<br><br>**F278:**<br>MDS diagnosis corrected for R96 on 3-3-2010 which eliminated the incorrect diagnosis of dehydration as a current diagnosis. The diagnosis list currently listed on the MDS reflects only current diagnosis(s).<br>(Attachment F278: 1). | 4/20/10<br><br>3/26/10 |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment | F 279 | MDS coding corrected for R99 on 3-15-2010<br>(Attachment F278: 2).<br>MDS coding corrected for R14 on 3-26-2010<br>(Attachment F278: 3).<br>All MDS coding relating to diagnosis, toileting and wound staging have the potential to be affected by this deficient practice.<br>An audit of all current MDSs for diagnosis and coding for toileting and wound staging will be completed by 4-1-2010 to ensure no other deficient practice and or correct. (Attachment F278: 4) | 4/1/10 |

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| F 279 | Continued From page 8 under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for three (R28, R16 and R131) out of 33 sampled residents failed to have a care plan for an identified care need. Findings include:<br><br>1. Cross refer F309 example #1<br>R28 was admitted to the facility on 1/20/10 following back surgery on 1/18/10. The resident was being treated daily for pain with routine and as needed (prn) pain medications.<br><br>The facility initiated a care plan for pain. The care plan failed to identify the location and intensity of the pain and failed to be revised when R28 developed a second source of pain. The care plan goal was to verbalize effectiveness (pain relief) by a decrease of pain by rating one point according to the pain scale within 30 minutes after intervention. The resident's pain assessment of an acceptable pain level of 3 - 4 with a goal of 0 -1 was not used in developing the care plan.<br><br>2. Cross refer F329 example #2<br>R28 was on Trazodone (an anti-depressant used for insomnia) every evening as needed for insomnia. The resident requested the medication almost every night. The resident did not have a care plan that addressed insomnia as a problem.<br><br>3. R16 had diagnoses that included fluid overload, peripheral edema, chronic obstructive pulmonary disease (COPD) and sleep apnea. The resident was taken to the hospital twice (12/4/09 and 1/2/10) during her confinement with | F 279 | **F278 continued:**<br>MDS Coordinator education regarding diagnosis and coding for toileting and wound staging by 4-1-2010. (Attachment F278: 5)<br>MDS Audit (Attachment 278: 6) will be completed weekly, prior to MDS submission, beginning 4/5/2010.<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame.<br><br>**F279:**<br>Resident #R28's care plan was reviewed and updated on 3-22-2010 for pain to include location and intensity of first pain site; comprehensive care plan for second pain site (Attachment F279: 1).<br>Resident #R28's care plan was reviewed and updated on 3-4-2010 for insomnia and effectiveness of medication in the treatment of insomnia (Attachment F279: 2).<br>Resident #R16 was LOA from facility until 3/26/2010 at which time the re-admission care plan was reviewed and updated on 3-26-2010 for fluid overload, peripheral edema, COPD and sleep apnea (Attachment F279: 3). | 4/1/10<br><br>4/5/10<br><br>3/22/10<br><br>3/4/10<br><br>3/26/10 |

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| F 279 | Continued From page 9<br>an exacerbation of one or more of these problems. Although the facility indicated they were initiating care plans for these problems none were available on the clinical record at the time of the survey.<br><br>4. Cross refer F309, example #2.<br>R131 was admitted to the facility on 2/1/10 with diagnosis including lower back pain. Review of the admission pain assessment dated 2/1/10 indicated R131 was experiencing pain in her right hip and R131's acceptable level of pain was "6" and her goal for pain control was "2."<br>A care plan for pain related to arthritis and chronic back pain implemented on 2/1/10 included expected outcomes. It also incorporated alternative methods of pain management will be assessed for and utilized through the confinement. In addition, R131 would verbalize effectiveness of the intervention by decrease of pain rating by one point on the pain scale. Interventions included staff to assess for level of pain using 0-10 pain scale, every shift if patient/resident complains of pain or receives analgesics. Although R131 conveyed her acceptable level of pain and goal for pain control, the care plan failed to incorporate this into the care plan.<br><br>Above findings reviewed with administration on 3/4/10 at approximately 3 PM. | F 279 | **F279 continued:**<br>Resident #R131's care plan was reviewed and updated on 3-6-2010 for pain management, including goal (Attachment F279: 4).<br>All residents have the potential to be affected by the same deficient practice with the following corrective actions to be taken:<br>Staff will be re-educated on comprehensive care plans beginning 4/5/2010 (Attachment F279: 5).<br><br>All care plans will be audited for appropriate interventions as indicated by resident diagnosis, need for pain management, and hypnotic/psychotropic medication. (Attachment F279: 6).<br><br>Audits will be completed on a weekly basis thereafter, in conjunction with care plan schedule (attachment F279: 6).<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 3/6/10<br><br>4/19/10<br><br>4/19/10<br><br>4/24/10 |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced | F 281 | | |

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| F 281 | Continued From page 10<br>by:<br>Based on clinical record review, observation, interview, and review of the facility's policy and professional references it was determined that for three (R28, R131, R34) out of 33 sampled residents the facility failed to ensure current standards of practice were implemented by professional staff. Two residents R28 and R131 pain management did not meet current standards of practice. For R34 facility staff crushed three medications that were not approved for crushing based on current standards. Findings include:<br><br>1. Cross refer F309, example #1.<br>The facility failed to ensure that the pain management for R28 met the professional standards of clinical practice as defined by the American Geriatrics Society. In particular, the facility failed to have a system which facilitated regular assessments of pain including intensity and location experienced by R28 and effectiveness of treatment.<br><br>2. Cross refer F309, example #2.<br>The facility failed to ensure that the pain management for R131 met the professional standards of clinical practice as defined by the American Geriatrics Society. In particular, the facility failed to have a system which facilitated regular assessments of pain and evaluation of the effectiveness of the interventions implemented for R131.<br><br>3. R34 was admitted to the facility on 12/9/10 with diagnoses that included hypertension, coronary artery disease, congestive heart failure and AAA 2.8 cm (Abdominal Aortic Aneurysm 2.8 centimeters). | F 281 | **F281:**<br>R28's pain management was corrected to meet professional standards. (CR F309).<br>R28's care and services includes pain management to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>R28's pain was reassessed beginning on 3/5/2010. Subsequent to the assessment(s), the plan of care was updated and changed beginning 3/5/2010 to include:<br>R28's acceptable level of pain was 3-4 out of 10 (represents "mild"/"discomforting") with a pain goal of 0-1 out of 10 (represents "no pain"/"mild").<br>Non-pharmaceutical interventions are exercise (ROM), physical therapy, occupational therapy, positioning, and relaxation techniques.<br>Physician notification with orders received:<br>March 5, 2010: Physician orders received to increase the frequency of PRN Oxcodone IR from every 6 hrs to every 4 hrs PRN;<br>Orders received from Neurosurgeon for MRI (scheduled for March 19, 2010) with follow-up; Neurosurgeon recommendation continuation of physical therapy. | 3/5/10 |

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| F 281 | Continued From page 11<br><br>During observation of medication administration for R34 on 2/26/10 at 10:05 AM, E23(RN) stated that the resident "gets all medications crushed." E23 crushed all of the medications to be given, except the Gabapentin 300 milligram capsule, and mixed them into pudding. Then E23 opened the Gabapentin capsule and mixed the contents into the pudding/medication mixture and administered the mixture to the resident with a spoon.<br><br>Review of the physician's orders signed on 2/10/10 did not reveal an order to crush medications.<br>The ordered medications that were crushed included:<br>1) Felodipine ER (extended release) 5 mg (milligram) tab. (tablet) SR 24H (hour) 1 tab by mouth every day<br>2) Isosorbide Mononitrate F/C 30 mg tab. SR (sustained release) 24H, 1 tab.by mouth every day for hypertension<br>3) Klor-Con M10 10 meq (millequivalents) tab PRT SR, 1 tab by mouth every day for supplement<br><br>Review of the Medication Administration Record (MAR) revealed that each entry for these medications included precautions against chewing and crushing. The Klor-Con entry on the MAR further indicated that it may be mixed in water. These medications were also listed on the "Do Not Crush" list located in the back of the MAR binder.<br><br>During an interview with E23 on 2/26/10 at 2:30 PM, when informed that the above listed medications should not have been crushed prior | F 281 | **F281 continued:**<br>March 10, 2010: Primary physician notified and order received for Oxycontin increase to 60 mg, twice per day.<br>March 16, 2010: Paxil increased to 40 mg, by mouth, daily. Oxycontin increased to 80mgs in morning, continue with 60 mgs in the evening. Neurosurgeon notified regarding pain, order received for lumbar MRI.<br>March 18, 2010: R28 physician visit to orthopedic surgeon results received that include: benign left knee exam and x-rays; mild evidence of L5/S1 root irritation-recommendations to continue to exercise bilateral lower extremities, frequent short walks, evaluation by neurosurgeon questionable residual lower back pain with scar tissue; no limitations with follow up in 6-8 weeks.<br>March 19, 2010: Primary care physician notified of pain and new order for Motrin 800 mg, every 8 hours as needed, received. MRI completed.<br>March 24, 2010: Primary care physician notified of pain with Oxycontin IR 10 mg 1 time dose. Neurosurgeon notified of MRI results and pain with new orders received for Medrol dose pack. Appointment made with Neurosurgeon for 3/26/2010.<br>March 26, 2010: Neurosurgeon appointment with no new medication orders received, continue physical | |

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| F 281 | Continued From page 12<br>to administration and they were listed on the "no crush list" in the MAR binder, the employee indicated that he did not know there was a "no crush list" in the MAR binder and went to the binder to look for it.<br><br>During an interview on 2/26/10 at 2:30 PM, the Pharmacist (E25) stated that the (above listed) pills should not have been crushed since they are sustained release or extended release.<br><br>During an interview on 2/26/10 at 2:30 PM, when informed that the administered medications listed above were crushed, the Charge Nurse (E24) and Education Coordinator (E5) indicated that the pills should not have been crushed.<br><br>During an interview on 3/1/10, the Director of Nursing (E2) was informed that the administered medications listed above were crushed. When asked E2 indicated that the facility utilizes standard references to include the "Omnicare Manual (facility's pharmacy), the Nurse's Guide to Drugs and the Physician's Desk reference" for medication administration.<br><br>Review of the "Omnicare, Inc. Policy #6.0 General Preparation and Medication Administration" dated 12/18/06, revealed "Applicability, This Section 6.0 sets forth the procedures relating to general dose preparation and medication administration."<br><br>"2. Dose preparation. 2.7 Facility staff should not crush oral medications without a physician/prescriber's order. Facility staff should crush oral medications only in accordance with Pharmacy guidelines and/or Facility policy." | F 281 | **F281 continued:**<br>therapy, occupational therapy and order to discharge home and follow up with pain management physician.<br>March 31, 2010: R28 discharged home.<br>Beginning March 5, 2010 through March 15, 2010, R28's pain rating prior to administration of an analgesic averaged 8 out of 10 (8 represents "terrible", according to facility pain assessment scale) and R28's pain rating, after receiving an analgesic, averaged 3 out of 10 (3 represents "mild/discomforting" according to the facility pain assessment scale), demonstrating the assessment of the effectiveness of the medication administered.<br>Beginning March 16, 2010 through March 26, 2010, R28's pain rating prior to administration of an analgesic averaged 7 out of 10 (7 represents "distressing/terrible") on the assessments documented. R28's pain rating, after receiving analgesic, averaged 4 out 10(4 represents "discomforting") on the assessments documented, demonstrating the assessment of the effectiveness of the medication administered.<br>March 27, 28, 29, 30, and on date of discharge, R28 did not require any PRN medications to manage pain.<br>R28 did not miss any therapy sessions due to pain, continued to progress and | |

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| F 281 | Continued From page 13<br>Review of the "PDR 2009 Edition of the Nurse's Drug Handbook" in the Garden Unit nursing station, revealed the following:<br>1) Felodipine - "Take medication whole and not to crush or chew the tablets."<br>2) Klor-Con - "Swallow tabs whole - may break in half and dissolve in 4 ounces of water."<br><br>Review of the "Nursing 2010 Drug Handbook" found on the Garden Unit, marked with "1st floor," revealed the following:<br>1) Felodipine - "Give drug whole, don't crush or cut tablets."<br>2) Klor-Con - "Don't crush sustained-released forms."<br>3) Isosrbide - "...swallow oral tablets whole." | F 281 | **F281 continued:**<br>meet defined goals up to and including a level of independence to return home which she accomplished on March 31, 2010.<br>(Attachment F309: 1).<br><br>R131's care and services includes pain management to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interviews and observation it was determined that two (R28 and R131) out of 33 sampled residents failed to receive the care and services necessary to ensure adequate pain relief. It was determined that the facility failed to reassess and failed to monitor the effectiveness of R28's pain management interventions related to lower back pain and knee pain. This failure and the failure in | F 309 | R131's pain was reassessed, by location, on 3/15/2010, to include lower back pain. Subsequent to the assessment, the plan of care was updated and changed on 3/15/2010 to include:<br>R131's acceptable level of pain was 6 out of 10 (6 represents "distressing") with a pain goal of 2 out of 10 (2 represents "mild").<br>Non-pharmaceutical interventions are positioning, touch stimulation, relaxation techniques, and distraction.<br>Physician notification with new orders:<br>March 8, 2010: Primary Physician changed order for Tramadol 50 mg, previously PRN, now twice per day.<br>March 9, 2010: Primary Physician initiated order for Tylenol 650 mg, every 6 hours PRN. | 3/15/10 |

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| F 309 | Continued From page 14<br>contacting the attending physician each time the medication was not effective resulted in the pain level remaining at unacceptable levels between 8 and 10. The facility failed to reassess and monitor the effectiveness of R131's pain management interventions as it related to resident's goals and current standards of practice. Findings include:<br><br>1. R28 was readmitted 1/20/10 post hospitalization following back surgery (microdiskectomy for L4/5 on 1/18/10). The resident's diagnoses included left total knee replacement (April 2009), diabetes, seizures, depression, pain, hypothyroidism, hypertension, and deconditioning/weakening. Hospital discharge orders for pain medications were oxycodone 10/325 mg 1 tab q 4 hours for pain and motrin 300 mg prn for pain.<br><br>The resident's initial pain medication orders were oxycontin 10 mg bid (twice a day) for pain, percocet 5/325 mg 1 tab for moderate pain or 2 tab for severe pain Q 4 - 6 hours prn as needed, and motrin 300 mg prn for pain (resident never requested or received dc'd 2/2/10).<br><br>R28 was alert and oriented. The resident admission MDS dated 1/30/10 documented the resident had pain and identified the sites as the back, joint and other unspecified sites with a frequency as daily and an intensity that was horrible to excruciating.<br><br>The resident's admission pain assessment (unsigned and undated) indicated the resident had daily pain to the lumbar back area that was throbbing and sharp. The resident rated her pain as a 10 on a 0 to 10 scale. R28 indicated her | F 309 | **F281 continued:**<br>March 11, 2010: Primary Physician initiated order for Lidoderm patch to lower back, daily.<br>For the period of March 5 through 30, 2010, R131's pain rating, prior to administration of analgesic, averaged 4.75 out of 10 (4.75 represents "discomforting") on the assessments documented. R131's pain rating after receiving analgesic averaged 1.5 out of 10 (1.5 represents "No Pain"/"Mild) on the assessments documented.<br><br>R131 did not miss any therapy sessions due to pain, continued to progress and meet defined goals up to and including "met maximum rehabilitation potential" on March 23, 2010 when she was discharged from skilled therapy. (Attachment F309: 2).<br><br>R131's pain management was corrected to meet professional standards (CR F309).<br><br>F34's physician's orders were corrected to include "All medications that can be crushed, may be crushed" on 2/26/2010 (Attachment 281: 1).<br>R34 has a physician's order, dated 2/26/2010, stating, "All medications that can be crushed may be crushed". (Attachment F332: 1) | 3/5/10 |

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| F 309 | Continued From page 15<br>acceptable level of pain was a 3 - 4 and her goal was to be 0 -1. The current pain management was listed as oxycodone every 12 hours and percocet as needed for breakthrough pain that was effective.<br><br>An interdisciplinary care plan was implemented on 1/20/10 for pain related to (facility did not identify). The care plan failed to identify the source of the resident's pain and failed to be revised when R28 developed a second source of pain. The expected outcome was "Resident name" will verbalize effectiveness by a decrease of pain by rating of one point according to the pain scale within 30 minutes after intervention. This was not the same goal assessed on the admission pain assessment of having her pain at an acceptable level for 3 -4 with a goal of 1 - 2.. Approaches included assessing effectiveness of pain control relief using 0 - 10 pain scale and record on MAR/24 interdisciplinary progress record after 30 minutes.<br><br>On 1/27/10 the resident was sent to the emergency room to have her left knee evaluated for swelling and pain. No injuries were identified to the left knee. On this same day the physician added a Lidoderm patch to the lower back on 12 hours off 12 hours for pain relief. R28 received prn medication for complaints of knee pain on an almost daily basis. At times two to three times a day.<br><br>There was no pain assessment documented for this new onset of knee swelling with pain. The facility's policy for Pain Management indicates a new assessment will be done with any new onset of pain. | F 309 | **F281 continued:**<br>Medication Administration Record of currently prescribed medications that have a physician's order to crush and crushing is permissible: Advair Diskus, Amiodarone, Aspirin, Atacand, Citalopram, Furosemide, Lidoderm, Lipitor, Magnesium Oxide, Metoprolol, Tartrate, Plavix, Polyethylene, Prosource Powder, Senna, Siriva, Acetaminophen, Alprazolam, Ear Drops, Guituss, Metoclopramide, Nitroglycerine, OxyCodone/APAP, and Ventolin HFA.<br>The following are prescribed and not crushable and are not crushed prior to administration: Oxybutynin Chloride, Isosorbide Mononitrate, Ferrous Sulfate Ranitidine, and Felodipine ER.<br>The following is administered by opening the capsule and expelling contents, but not crushed: Gabapentin.<br>Oral medications are administered in accordance with Pharmacy guidelines and/or facility policy which includes the exclusion of medications that appear on the "no crush list", located in the MAR and/or in accordance with Pharmacy guidelines (Section 6.0; 2. Dose Preparation). | |

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| F 309 | Continued From page 16<br>The pain management standards were approved by JCAHO in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002 which include:<br><br>-appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.<br><br>The facility failed to use a quantitative pain assessment to evaluate the level of pain and effectiveness of the treatment. The facility failed to describe the pain and failed to differentiate between pain sources with individual assessments.<br><br>The facility's pain scale contained in the Pain Management and Assessment Procedure documents 0 = no pain, 2 = mild, 4 = discomforting, 6 = distressing, 8 = terrible, and 10 = excruciating.<br><br>An interview on 3/2/10 at 11 am with a nurse E15 , revealed that the practice of the facility is to rate pain with the scale, give the medication and go back in about an hour and use the scale again to rate the pain.<br><br>The facility documented pain every shift using the pain scale on the MAR. For the month of February 2010 the resident's pain was rated between 8 -10 for 50 out of the 84 opportunities or 60% of the time. | F 309 | **F281 continued:**<br>All residents who experience pain have the potential to be affected by the same deficient practice (CR F309).<br>All residents who receive medications that are crushed have the potential to be affected by the same deficient practice.<br><br>Licensed staff education regarding professional standards for pain management (CR F309), including regular assessments and evaluation of effectiveness of the interventions.<br>Licensed staff re-education regarding medication administration, via crush, beginning 4/7/2010, to include physician's order and medications that are indicated as "do not crush" (Attachment F281: 2).<br><br>Audit of pain management professional standard initiated 4/5/2010 (Attachment F281 :3/CR F309).<br>Audit of medication administration practice, with regards to crushing, initiated 3/31/2010 (Attachment F281: 4).<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/21/10<br><br>4/21/10 |

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| F 309 | Continued From page 17<br>During the Month of February 2010 R28 received 61 doses of prn pain medication (percocet and/or oxycodone) for breakthrough pain. For 30 of those doses her pain level was rated at a 10, 11 doses at a level of 9, 10 doses at a level 8, 2 doses at a level 7, 3 doses at a level 6, 1 dose at a level 5 and 4 doses in which the level was not documented.<br><br>Review of the February 2010 MAR revealed 26 out of 61 prn pain medications (43%) had no scale used to evaluate the effectiveness of the medication. For 11 out of 61 (6%) of the prn medications the resident rated pain after administration at a 6 - 8 (distressing to terrible). The resident's acceptable pain level is 3 - 4.<br><br>On 2/11/10 R28's every 12 hour oxycodone dose was increased from 10 mg to 20 mg for pain. This was administered twice daily at 9 AM and 9 PM. On 2/14/10 a heat pack (kmod) was ordered for use on the resident's lower back to relieve pain. There was also an order to initiate electrical stimulation and biofeedback in therapy.<br><br>On 2/21/10 R28 had two falls landing on her knees. X-rays were obtained but were negative for fracture. The resident's twice a day oxycodone was increased from 20 mg to 40 mg for pain. The percocet as needed order remained in place and was requested every 6 hours by R28.<br><br>On 2/25/10 at 9 am R28 verbalized pain at a 10/10 and was not due for an as needed dose of percocet. The nurse called the physician and obtained a one time order for percocet 5/325 mg 2 tabs now. Later that day the percocet prn was discontinued and oxycodone 10 mg q 6 hours as needed for pain was initiated. The resident | F 309 | **F309:**<br>R28's care and services includes pain management to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>R28's pain was reassessed beginning on 3/5/2010. Subsequent to the assessment(s), the plan of care was updated and changed beginning 3/5/2010 to include:<br>R28's acceptable level of pain was 3-4 out of 10 (represents "mild"/"discomforting") with a pain goal of 0-1 out of 10 (represents "no pain"/"mild").<br>Non-pharmaceutical interventions are exercise (ROM), physical therapy, occupational therapy, positioning, and relaxation techniques.<br>Physician notification with orders received:<br>March 5, 2010: Physician orders received to increase the frequency of PRN Oxcodone IR from every 6 hrs to every 4 hrs PRN;<br>Orders received from Neurosurgeon for MRI (scheduled for March 19, 2010) with follow-up; Neurosurgeon recommendation continuation of physical therapy.<br>March 10, 2010: Primary physician notified and order received for Oxycontin increase to 60 mg, twice per day. | 4/1/10 |

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| F 309 | Continued From page 18<br>continued with oxycodone 40 mg bid for pain.<br><br>From March 1 - March 4, 2010 review of the MAR revealed 10 doses of prn pain medication was administered. Six out of ten doses were for pain at a level of 8 -10. Two doses of medication had no scaled assessment before administration. Only 2 out of ten doses used the scale to evaluate the effectiveness of the medication.<br><br>On 3/2/10 a one time order of oxycodone 10 mg was administered at 11:50 am due to pain at a 10/10 level when the resident was not due for her ordered prn dose. The 9 PM dose of oxycodone was increased to 60 mg. However, with these medication adjustments the resident continued to have pain at a level of 10/10.<br><br>On 3/3/10 the resident had a EMG of the left knee. Knee and back x-rays were ordered to be done on 3/4/10. Follow-up visits with the orthopaedist and neurosurgeon were scheduled for the next week. No results were available at the conclusion of the survey. Use of hot or cold therapy had been put on hold by the neurosurgeon.<br><br>On 3/4/10 at 9:20 am the resident stated her pain remained a 10/10 and she had her last dose of prn percocet at 7 am.<br><br>The facility's pain policy stated that any resident who states or displays evidence of ineffective pain management the attending physician is to be notified as well as completion of the appropriate pain assessment. The policy also stated that a pain scale rating prior to and after administration of an analgesic and as necessary will be documented to the back of the MAR. | F 309 | **F309 continued:**<br>March 16, 2010: Paxil increased to 40 mg, by mouth, daily. Oxycontin increased to 80mgs in morning, continue with 60 mgs in the evening. Neurosurgeon notified regarding pain, order received for lumbar MRI.<br>March 18, 2010: R28 physician visit to orthopedic surgeon results received that include: benign left knee exam and x-rays; mild evidence of L5/S1 root irritation-recommendations to continue to exercise bilateral lower extremities, frequent short walks, evaluation by neurosurgeon questionable residual lower back pain with scar tissue; no limitations with follow up in 6-8 weeks.<br>March 19, 2010: Primary care physician notified of pain and new order for Motrin 800 mg, every 8 hours as needed, received. MRI completed.<br>March 24, 2010: Primary care physician notified of pain with Oxycontin IR 10 mg 1 time dose. Neurosurgeon notified of MRI results and pain with new orders received for Medrol dose pack. Appointment made with Neurosurgeon for 3/26/2010.<br>March 26, 2010: Neurosurgeon appointment with no new medication orders received, continue physical therapy, occupational therapy and order to discharge home and follow up with pain management physician. | |

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| F 309 | Continued From page 19<br><br>The facility was not using an assessment or pain scale to determine the level of pain for the administration of oxycodone bid only for the prn doses of percocet or oxycodone. There was not an assessment in place to evaluate the effectiveness of the routine pain medication. The facility was also failed to differentiate between the site of pain and often documented "lower back / knee" when administering prn pain medication.<br><br>Conversations by surveyors with the R28 on 2/24/10 and 3/1 - 3/4/10 revealed her pain level was at a 10. She further revealed that the pain medications she was on were not giving her relief and she had told this to the doctor last week. She also stated that the nurses did not always use the numerical scale to rate her pain and/or medication effectiveness. Review of nurses notes described the residents pain and frustration with lack of pain management;<br><br>- On 2/24/10 during an interview the resident stated that her medication had just been changed from 20 mg to 40 mg (oxycodone BID 2/23) but has not helped yet. She further stated that she had told the doctor and the nurses that the medication was not helping her pain calm down.<br><br>- Observation on a medication pass on 2/24/10 at 12:05 PM the resident rated her pain as a 10/10. Her last dose of prn percocet was at 6:15 am for pain at a 10/10. There was no documentation of the relief from that dose. The relief from the 12:05 PM dose was 7/10 (distressing to terrible).<br><br>- On 3/1/10 at 2:30 PM the resident told the surveyor that the pain meds do not give her relief and she told this to the doctor last week. She also | F 309 | **F309 continued:**<br>March 31, 2010: R28 discharged home.<br>Beginning March 5, 2010 through March 15, 2010, R28's pain rating prior to administration of an analgesic averaged 8 out of 10 (8 represents "terrible", according to facility pain assessment scale) and R28's pain rating, after receiving an analgesic, averaged 3 out of 10 (3 represents "mild/discomforting" according to the facility pain assessment scale), demonstrating the assessment of the effectiveness of the medication administered.<br>Beginning March 16, 2010 through March 26, 2010, R28's pain rating prior to administration of an analgesic averaged 7 out of 10 (7 represents "distressing/terrible") on the assessments documented. R28's pain rating, after receiving analgesic, averaged 4 out 10(4 represents "discomforting") on the assessments documented, demonstrating the assessment of the effectiveness of the medication administered.<br>March 27, 28, 29, 30, and on date of discharge, R28 did not require any PRN medications to manage pain.<br>R28 did not miss any therapy sessions due to pain, continued to progress and meet defined goals up to and including a level of independence to return home | |

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| F 309 | Continued From page 20<br>stated that the pain scale is not always used and the staff don't always come back to see if the pain medication was effective.<br><br>- Nurse's note 3/2/10 7:30 am "states constant pain is starting to get to her...frustrated at present".<br><br>- On 3/2/10 R28 told the surveyor that her pain medications were not working. At 11 AM her nurse E15, stated that it seems her every 6 hour prn pain medication was not holding her since she has had it at 7 am and was going to call the doctor to ask for something else for pain. The doctor gave a one time only order for 10 mg of oxycodone that was administered at 11:50 am. No documentation could be found to evaluate if this was effective.<br><br>- Nurse's note 3/2/10 11:50 am "patient continues to have pain current pain management is not effective for her pain awaiting MD response".<br><br>- Nurse's note 3/2/10 9:40 PM "pain medications ineffective. patient found crying in bed r/t pain. (Doctor name) paged".<br><br>- Nurse's note 3/2/10 10:11 PM "Doctor returned phone call. Change in medication dosage ordered... Patient dissatisfied stating she wants to speak to doctor re: pain MD made aware".<br><br>- Nurse's note 3/3/10 8:30 am "Resident medicated x2 for breakthrough pain this shift. States is effective sometimes, but mostly it is not. Stated she was upset about constantly being in pain and needed something done".<br><br>- Nurse's note 3/3/10 8:30 am "concerned about | F 309 | **F309 continued:**<br>which she accomplished on March 31, 2010.<br>(Attachment F309: 1).<br><br>R131's care and services includes pain management to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br>R131's pain was reassessed, by location, on 3/15/2010, to include lower back pain.<br>Subsequent to the assessment, the plan of care was updated and changed on 3/15/2010 to include:<br>R131's acceptable level of pain was 6 out of 10 (6 represents "distressing") with a pain goal of 2 out of 10 (2 represents "mild").<br>Non-pharmaceutical interventions are positioning, touch stimulation, relaxation techniques, and distraction.<br>Physician notification with new orders:<br>March 8, 2010: Primary Physician changed order for Tramadol 50 mg, previously PRN, now twice per day.<br>March 9, 2010: Primary Physician initiated order for Tylenol 650 mg, every 6 hours PRN.<br>March 11, 2010: Primary Physician initiated order for Lidoderm patch to lower back, daily. | 4/1/10 |

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| F 309 | Continued From page 21<br>what is going to happen to decrease pain levels". (different nurse)<br><br>- 3/3/10 9:15 am the resident was observed with tears in her eyes, complained about pain and medications not working and was upset the physician never came in to talk to her last night about her pain.<br><br>- Nurse's note 3/3/10 8:58 PM "Doctor in to see patient tonight to discuss pain...No new orders. Will see how oxycodone increase works and will continue to reassess pain"<br><br>- Nurse's note 3/4/10 8:35 am "Oxycodone IR given x 2 this shift and had some effect for pain. Resident states she needs something else but will wait until seeing ortho Friday".<br><br>- On 3/4/10 at 9:20 am the resident stated her pain was a 10/10. Her last dose of oxycodone 10 mg prn was at 6:50 am (no effect documented) and her routine dose of oxycodone 40 mg was at 9 am. She stated the doctor increased her 9 PM oxycodone to 60 mg on 3/2/10 but she was still waiting to see the effect of it.<br><br>- Review of therapy notes and interview with therapy staff E9 and E10 3/4/10 revealed that R28 participates in therapy despite her pain issues. The resident was working on ambulation, transfers, and muscle strengthening. The resident did complain of not feeling well 3/2/10 and returned to her room before the end of the therapy session. Therapy has been using electrical stimulation to help with the pain.<br><br>An interview with the ADON E3, on 3/3/10 revealed that the facility had become aware of the | F 309 | **F309 continued:**<br>For the period of March 5 through 30, 2010, R131's pain rating, prior to administration of analgesic, averaged 4.75 out of 10 (4.75 represents "discomforting") on the assessments documented. R131's pain rating after receiving analgesic averaged 1.5 out of 10 (1.5 represents "No Pain"/"Mild) on the assessments documented.<br><br>R131 did not miss any therapy sessions due to pain, continued to progress and meet defined goals up to and including "met maximum rehabilitation potential" on March 23, 2010 when she was discharged from skilled therapy. (Attachment F309: 2).<br><br>All residents experiencing pain and/or receiving physician ordered pain medication have the potential to be affected by the same deficient practice.<br>Staff (all) education on pain management; to be initiated by 3/30/2010 (Attachment F309: 3).<br>Licensed staff (RNs and LPNs) will be educated on revised Pain Management Policy and related forms(Attachment F309: 2) beginning 4/5/2010 (Attachment F309: 4).<br><br>Audits of pain management will be completed on a weekly basis beginning | 4/21/10 |

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| F 309 | Continued From page 22<br>increased pain in the last week and called to get an earlier appointment with the surgeon. X-rays of the knee and back were also ordered to be done on 3/3 or 3/4/10.<br><br>An interview with the physician E18 on 3/8/10 at 1:30 PM revealed that R28 was a post-op short term rehabilitation patient that had been back to the orthopaedic doctor 3 times since admission for pain to knees and back with no resolution. All testing so far has only shown degenerative joint disease. Pain medications have been increased several times. At this point he has her on oxycodone 60 mg bid and 15 mg prn q 4 hours for pain. His worry now is overdose of medication with these significant increases. He stated that her pain complaints may be exaggerated based on her lack of response to the significant medication increases. He stated that when she finishes her work up with the orthopedist and the neurosurgeon and completed her therapy rehab she may need to be seen by a pain management specialist.<br><br>Although the facility initially assessed R28's lower back and knee pain and implemented new interventions for pain management, the facility failed to reassess and monitor the effectiveness of these interventions as it related to the resident's goals and current standards of practice. From 2/24/10 - 3/3/10 nurses notes document the resident's ongoing concerns about pain and lack of physician accessibility to the resident. The facility failed to communicate with the physician when the resident's pain was not adequately managed. Due to these multiple failures, R28 was found to be in terrible to excruciating pain during the survey. | F 309 | **F309 continued:**<br>4/5/2010 (Attachment F309: 5). Staff will intervene to correct any issues identified at the time of audit.<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/21/10 |

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| F 309 | Continued From page 23<br><br>2. R131 was originally admitted to the facility on 2/1/10 from the hospital with diagnoses including low back pain, ambulatory dysfunction, and urinary tract infection. The admission and 14 day Minimum Data Set (MDS) assessments dated 2/8/10 and 2/15/10 noted R131 did not have any impairment in daily decision making and experienced moderate intensity of pain less than on a daily basis in her back.<br><br>Review of the admission pain assessment dated 2/1/10 indicated R131 was experiencing pain in her right hip and could verbalize pain on a scale of 0-10 and R131's acceptable level of pain was "6" and her goal for pain control was "2."<br><br>A care plan for pain related to arthritis and chronic back pain implemented on 2/1/10 stated expected outcomes included alternative methods of pain management would be assessed for and utilized through the confinement. In addition, R131 would verbalize effectiveness of the intervention by decrease of pain rating by one point on the pain scale. Interventions included staff to assess for level of pain using 0-10 pain scale, every shift if patient/resident complains of pain or receives analgesics. Although R131 conveyed her acceptable level of pain and goal for pain control, the care plan failed to incorporate this into the care plan.<br><br>Review of the February 2010 MAR revealed R131 requested and was administered a total of 32 doses of Tramadol 50 mg. by mouth for complaints of pain. Out of the 32 doses, pain scale to assess for the effectiveness of the medication was only utilized for seven administrations. In addition, the assessment | F 309 | | |

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| F 309 | Continued From page 24<br>failed to include the location of the pain for which the medication was given.<br><br>Review of the facility ' s policy titled " Pain Management and Assessment " indicated through a collaborative interdisciplinary approach, effectiveness of pain management will be assessed on an ongoing basis.<br><br>Review of physical therapy (P.T.) note dated 2/24/10 documented that R131 was unable to tolerate standing due to right hip pain.<br><br>Review of the "Subacute transduction team care plan conference" note dated 3/1/10 lacked evidence that pain interventions were discussed even though R131's level of pain, as noted on the 2/24/10 P.T. note was impacting her ability to participate in therapy.<br><br>Additional review of P.T. note on 3/2/10 documented that R131 was unable to participate in therapy due to right hip pain on a pain scale of "6."<br><br>The current pain management standards by the American Geriatrics Society includes:<br>- appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.<br><br>Although the facility thoroughly assessed R131's right hip pain on admission and implemented interventions, the facility failed to reassess and | F 309 | | |

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| F 309 | Continued From page 25<br>monitor the effectiveness of R131's pain management interventions as it related to resident's goals and current standards of practice.<br><br>Above findings were reviewed with administration on 3/4/10 at approximately 2:25 PM. | F 309 | **F329:**<br>R34 no longer resides at this facility. R28's care plan was reviewed and updated on 3/4/2010 with goals for insomnia to include non-pharmaceutical interventions . Resident 34's stated care plan goals include "(R34) will verbalize increased sense of well being and feeling rested" and "(R34) will sleep 7-8 hours during nighttime thru the next review". Non-pharmaceutical interventions included: 1. As able, determine normal sleep patterns and establish goals for rest/sleep accordingly; 2. Assist to position of comfort for sleep, reducing noise and light in the environment; 3. Encourage participation in physical activity during daytime hours as tolerated to expend energy and ready for sleep; 4. Avoid interruptions of sleep during the night as much as possible. Pharmaceutical interventions include: 1. Administer medications as prescribed for insomnia. Assess benefit and for any side effects-medications: Trazadone 50 mg q hs PRN for sleep. Physician's order on 3/4/2010 increased the Trazadone dosage from 25 mg q hs to 50 mg q hs (Attachment F329: 1). For the period of March 5, 2010 through March 30, 2010 , R34 received Trazadone 50mg for insomnia 21 times in 26 days during the period of March 5, 2010 to her discharge on March 30, 2010(81%). Of these, 19 | 3/4/10 |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for two (R34 and R28) out of 33 | F 329 | | |

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| F 329 | Continued From page 26<br>residents in the sample, the facility failed to ensure adequate monitoring and indication for the use of medications was present. The facility failed to adequately monitor the use of R34's anti-anxiety medication Xanax. The facility failed to monitor R28's use of Trazodone for insomnia.<br><br>Findings include:<br><br>1. Review of R34's February 2010 Medication Administration Record (MAR) revealed the resident received eight doses of Xanax 0.25 mg. (milligram) as needed on 2/3/10, 2/10/10, 2/11/10, 2/12/10, 2/13/10, 2/14/10, 2/21/10, and 2/22/10. The effectiveness of the medication was noted on the back of the MAR as positive effect.<br><br>Review of the facility's policy on monitoring behavior symptoms titled "Behavior Intervention Monthly Flow Record Documentation" revealed that all residents who use psychoactive medication will have their behavior symptoms documented on the "Behavior/Intervention Monthly Flow Record (BIMFR)." Additionally, the facility will utilize this flow record to monitor potential side effects of the medication.<br><br>Record review lacked BIMFR documentation for February 2010. Interview with the Nurse Supervisor (E7) on 3/3/10 at approximately 10 AM revealed that R34 did not have any behavior symptoms in which the facility was monitoring eventhough the resident was receiving Xanax as needed. In addition, an interview with the assigned Certified Nursing Assistant (E8) on 3/3/10 at approximately 12 noon revealed that R34 was not being monitored for any behaviors.<br><br>Interview with the Unit Manager (E3) on 3/4/10 at | F 329 | **F329 continued:**<br>administrations had good effect which met the care plan goal (90%).<br><br>All residents who receive antipsychotic drugs have the potential to be affected by the same deficient practice.<br>All residents' drug regimen that includes antipsychotic drugs will be audited, beginning 3/31/2010 to ensure that they are free from unnecessary drugs: dosage (including duplicate therapy), duration, monitoring, indications for use, and adverse consequences (Attachment F329: 3). Licensed staff (RNs and LPNs) will intervene to correct any variances to policy.<br>Staff education (RNs, LPNs, C.N.A.s, Social Services, Activities) Behavior Intervention Monthly Flow Record (BIMFR) policy and documentation (Attachment F329: 4).<br>Staff education (RNs and LPNs) on drug regimen standards of practice to include symptoms as an indication for the use of medications, dosage (including duplicate therapy), duration, adequate monitoring for effectiveness and side effects, and adverse consequences (Attachment F329: 5).<br>Audits will be completed on a monthly basis, beginning 3/31/2010. Staff will intervene to correct any issues identified at the time of audit (Attachment F329: 6). | 4/19/10<br><br>4/19/10 |

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| F 329 | Continued From page 27<br>approximately 10 AM confirmed that the facility failed to adequately monitor the use of Xanax for R34.<br>2. R28 had a physician's order dated 2/16/10 for Trazodone 25 mg by mouth every evening as needed for insomnia.<br><br>Trazodone was administered 11 times in February but only documented on the back of MAR with a reason 9 times. Only 4 times did the nurse document whether or not the medication was effective. Trazodone was changed to 50 mg on 3/2/10 and administered on 3/2/10 and 3/3/10 with no evaluation of the effectiveness.<br><br>R28 did not have a care plan for insomnia. Interview with the resident on 3/1/10 revealed that she was taking trazodone for sleeping but it did not work. She stated she was up a lot at night and goes between the chair and the bed all night due to pain and inability to sleep.<br><br>An interview with nurse E15 on 3/2/10 at 11 am revealed that R28 has told her she wakes up at 3 am and cannot sleep during the night. The nurse stated she would talk to the doctor about this concern.<br><br>There was no evidence that non-pharmaceutical interventions were attempted or in place. The use of Trazodone was not evaluated for effectiveness each time it was used. | F 329 | **F329 continued:**<br>Results of the audits to be reviewed at monthly performance improvement meetings, Professional Practice Committee. Further audit necessity will be determined after a 3 month time frame. | 4/23/10 |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater. | F 332 | | |

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|---|---|---|---|
| | 085040 | A. BUILDING _____ B. WING _____ | C 03/04/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFECARE AT LOFLAND PARK | 715 E. KING STREET SEAFORD, DE 19973 |

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| F 332 | Continued From page 28<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medication administration observations, staff interviews, clinical record reviews and review of the facility's policy and professional references, the facility failed to administer medications with an error rate of less than 5%.<br><br>Findings include:<br><br>Multiple medication administration observations were made on 2/23/10, 2/26/10 and 3/2/10, for a total of 10 residents, on all 3 nursing units, with multiple nurses. There were 52 opportunities observed with 3 errors, resulting in an error rate of 5.77%.<br><br>Observation of medication pass for R34 on 2/26/10 at 10:05 AM, by E23(RN), revealed that the resident was to receive medications that included:<br>1) Felodipine ER (extended release) 5 mg (milligram) tab. (tablet) SR 24H (hour) 1 tab by mouth every day<br>2) Isosorbide Mononitrate F/C 30 mg tab. SR (sustained release) 24H, 1 tab by mouth every day for hypertension<br>3) Klor-Con M10 10 meq (millequivalents) tab PRT SR, 1 tab by mouth every day for supplement<br><br>E23 stated that the resident "gets all medications crushed" and proceeded to crush all of the medications, except the Gabapentin 300 milligram capsule. The medications were then mixed into pudding. Then E23 opened a Gabapentin capsule and mixed the contents into the pudding/medication mixture and administered | F 332 | **F332:**<br>R34 has a physician's order, dated 2/26/2010, stating, "All medications that can be crushed may be crushed". (Attachment F332: 1)<br>Medication Administration Record of currently prescribed medications that have a physician's order to crush and crushing is permissible: Advair Diskus, Amiodarone, Aspirin, Atacand, Citalopram, Furosemide, Lidoderm, Lipitor, Magnesium Oxide, Metoprolol, Tartrate, Plavix, Polyethylene, Prosource Powder, Senna, Siriva, Acetaminophen, Alprazolam, Ear Drops, Guituss, Metoclopramide, Nitroglycerine, OxyCodone/APAP, and Ventolin HFA.<br>The following are prescribed and not crushable and are not crushed prior to administration: Oxybutynin Chloride, Isosorbide Mononitrate, Ferrous Sulfate Ranitidine, and Felodipine ER.<br>The following is administered by opening the capsule and expelling contents, but not crushed: Gabapentin.<br>Oral medications are administered in accordance with Pharmacy guidelines and/or facility policy which includes the exclusion of medications that appear on the "no crush list", located in the MAR and/or in accordance with Pharmacy guidelines (Section 6.0; 2. Dose Preparation). | 3/15/10 |

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| F 332 | Continued From page 29<br>the mixture to the resident with a spoon.<br><br>Review of the 2/10/10 signed physician's orders verified that the medications listed above were to be administered but did not reveal an order to crush the medications.<br><br>Review of the MAR revealed that each of these medication entries included precautions against chewing and crushing. The Klor-Con entry on the MAR indicated that it may be mixed in water. These medications were also included on the "Do Not Crush" list located on the back of the MAR binder.<br><br>During an interview on 2/26/10 at 2:30 PM, E23 when informed that the above listed medications should not have been crushed prior to administration and that they were included on the "no crush list" in the MAR binder, the employee indicated that he did not know there was a "no crush list" in the MAR binder and went to the binder to look for it.<br><br>During an interview on 2/26/10 at 2:30 PM, the Pharmacist (E25)stated that the (above listed) pills should not have been crushed since they are sustained release or extended release.<br><br>During an interview on 2/26/10 at 2:30 PM, the Charge Nurse (E24) and Education Coordinator (E5) indicated that the pills should not have been crushed.<br><br>During an interview on 3/1/10, the Director of Nursing (E2) was informed that the administered medications listed above were crushed. When asked, indicated that the facility utilizes standard | F 332 | **F332 continued:**<br>All residents whose drugs are administered through crushing have the potential to be affected by the same deficient practice.<br>An audit of all residents who receive crushed medications will be begin by 3/31/2010 for physician order and proper medication administration in compliance with "no crush list" and Pharmacy guidelines (Attachment F332: 2). Identified variances will be corrected at the time of the audit by licensed staff.<br><br>RN and LPN re-education on medication administration for crushed medications beginning 4/5/2010 (Attachment F332: 3).<br><br>Monthly medication administration audits beginning 4/19/2010 for proper RN/LPN technique and practice, according to physician order, and facility policy (Attachment F332: 4).<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/19/10<br><br>4/19/10<br><br>4/19/10 |

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| F 332 | Continued From page 30<br>references to include the "Omnicare Manual, the Nurse's Guide to Drugs and the Physician's Desk reference" for medication Administration.<br><br>Review of the "Omnicare, Inc. Policy #6.0 General Preparation and Medication Administration" dated 12/18/06, reveled "Applicability, This Section 6.0 sets forth the procedures relating to general dose preparation and medication administration."<br><br>"2. Dose preparation. 2.7 Facility staff should not crush oral medications without a physician/prescriber ' s order. Facility staff should crush oral medications only in accordance with Pharmacy guidelines and/or Facility policy."<br><br>Review of the "PDR 2009 Edition of the Nurse's Drug Handbook" revealed the following:<br>1) Felodipine - "Take medication whole and not to crush or chew the tablets."<br>2) Klor-Con - "Swallow tabs whole - may break in half and dissolve in 4 ounces of water."<br><br>Review of the "Nursing 2010 Drug Handbook" found on the Garden Unit, marked with "1st floor" revealed the following:<br>1) Felodipine - "Give drug whole, don't crush or cut tablets."<br>2) Klor-Con - "Don't crush sustained-released forms "<br>3) Isosrbide - "...swallow oral tablets whole." | F 332 | | |
| F 425 SS=D | 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit | F 425 | | |

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| F 425 | Continued From page 31<br>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews and review of facility policy, it was determined that facility failed to ensure the timely identification and removal of expired medications from the current supply of non-expired medications stored in the first floor medication room.<br><br>The findings include:<br><br>Observation on 3/1/10 at approximately 2:15 PM in the first floor nursing unit medication room, accompanied by nurse E22(LPN), revealed expired medications stored in the medication refrigerator and on the medication "overflow" shelf.<br><br>The medication refrigerator contained the following expired medications: | F 425 | **F425:**<br>No residents received the expired medications identified.<br>Medications were immediately removed as they were identified as expired.<br><br>All residents have the potential to be affected by the deficient practice.<br>Audit of all medication storage areas conducted on 3/31/2010 (Attachment F425: 1) with staff intervention to correct any issued identified at the time of the audit.<br><br>Staff education beginning 4/5/2010 on audit procedures and proper surveillance of medications in all areas where medications are stored (Attachment F425: 2)<br><br>Audits will be completed on a weekly basis beginning 4/7/2010 of all medication storage areas (Attachment F425: 3).<br><br>Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 3/31/10<br><br>4/9/10<br><br>4/7/10<br><br>4/12/10 |

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| F 425 | Continued From page 32<br>1) One - 10 ounce bottle of Magnesium Citrate with an expiration date was 7/2009. The bottle had a large amount of tan colored sediment at the bottom.<br>2) One - 10 ounce bottle of Magnesium Citrate with an expiration date of 11/2009.<br>3) One - 5 milliliter vial of Influenza virus vaccine (Fluvirin) had an expiration date of 6/30/2009. The vial contained a small amount of vaccine.<br><br>The Overflow shelf in the medication room contained the following expired medication:<br>1) One (Albuterol) inhaler with an expiration date of 12/2008 and labeled with the name of R25 mixed in with non-expired medications with individual residents names on the labels.<br><br>During an interview with E22 at the time of the observation verified the medications were expired. The employee stated that the "Pharmacy is responsible for checking expiration of medications in the medication room." The employee further stated that the facility had no established schedule for the medication room to be checked for expired medications.<br><br>Interviews with the first floor unit Charge Nurse (E24) and the Education Coordinator (E5) on 3/1/10 at 2:45 verified that there was no established routine schedule to ensure that the medication room was checked for expired drugs. The Charge Nurse indicated that the nurses check the expiration dates when they administer medications.<br><br>Review of the facility policy dated 12/18/06 revealed the following: | F 425 | | |

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| F 425 | Continued From page 33<br>"Omnicare, Inc. Policy #5.3 Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles" with applicability to "LTC (Long Term Care) Facilities Receiving Pharmacy Products and Services from Pharmacy" indicated:<br><br>"3. The facility should ensure that drugs and biological that: (1) have an expired date on the label; 2) have been retained longer than recommended by manufacturer or supplier guidelines; or 3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier."<br><br>"13. The facility should destroy or return all discontinued, outdated/expired, or deteriorated drugs or biological in accordance with Pharmacy return/destruction guidelines."<br><br>"14. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis." | F 425 | **F441:**<br>E9, responsible for transporting R167 to therapy, received immediate (2/24/2010) documented re-education from this incident (Attachment F441: 1). | 2/24/10 |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and | F 441 | Disciplinary action was implemented for repeated infraction of same incident on 3/1/2010 (Attachment F441: 2).<br><br>All residents, staff, and facility visitors have the potential to be affected by the same deficient practice.<br>Infection Control re-education of all staff who would transport residents that are on contact precautions (RNs, LPNs, C.N.A.s, Therapy, Activities) beginning 4/5/2010 (Attachment F441: 4) as indicated by facility infection control policy. | 3/1/10<br><br>4/19/10 |

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| F 441 | Continued From page 34<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and review of other facility documentation, the facility failed to provide a safe, sanitary, and comfortable environment, to prevent the development and transmission of disease and infection for one (R167) out of 33 residents sampled. Findings include:<br><br>R167 was observed on 2/24/10 at approximately 10:35 AM wearing personal protective equipment gown and gloves and being transported by therapy department staff (E9) who also had on both gown and gloves. E9 proceeded to use the | F 441 | **F441 continued:**<br>An audit of staff practice (RNs, LPNs, C.N.A.s, Therapy, Activities) will follow education for return demonstration and skill proficiency in the transportation of residents that are on contact precautions (Attachment F441: 5).<br><br>Audits will be completed weekly, beginning 4/1/2010 (Attachment F441: 6). Staff will intervene to correct any deficient practice at the time of the audit. Results of the audit will be submitted to Director of Nursing and Professional Practice Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. | 4/9/10<br><br>4/23/10 |

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| F 441 | Continued From page 35<br>gloved hand to activate the button for the elevator. Subsequent observation of R167 on 3/1/10 at approximately 11:15 PM revealed R167 being transported in a wheelchair by E9 who had gloves on and proceeded to activate the button for the elevator.<br><br>An interview with a staff nurse (E13) on 2/24/10 at approximately 11 AM revealed that R167 was on contact precaution due to an abdominal wound infection with Vancomycin Resistant Enterococcus (VRE) organism. Review of R167's March 2010 Physician's Order Sheet noted an order for contact precaution for VRE.<br><br>Review of facility's policy titled "Contact Precautions Protocol" indicated for transporting resident, "immediately before leaving room with the resident, remove gown and gloves at doorway and discard in trash can. Clean hands."<br><br>Interview with the Program Director of Therapy (E10) on 3/3/10 at approximately 2 PM confirmed that above policy was not followed by the facility staff, thus, failed to help prevent the development and transmission of the disease and infection. | F 441 | | |

**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

**STATE SURVEY REPORT**





**NAME OF FACILITY:** Life Care at Lofland Park

**DATE SURVEY COMPLETED:** March 4, 2010

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---|---|---|
| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An annual survey and complaint visit was conducted at the facility from February 23, 2010 through March 4, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included forty (40) census and thirty (30) admission residents in Stage I. The Stage II sample included twenty-four (24) residents. | |
| **3201** | **Regulations for Skilled and Intermediate Care Nursing Facilities** | |
| **3201.6.1** | **General Services** | |
| **3201.6.1.1** | **The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**<br><br>**This requirement is not met as evidenced by:** | |

Provider gnature Wendy A. Mead, NHA Title Administrator Date April 16, 2010

NAME OF FACILITY: Life Care at Lofland Park

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| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
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| | Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F225, F241, F281, F309, F329, F332, F425, and F441. | 3201.6.1.1<br>Cross-refer: F225, F241, F281, F309, F329, F332, F425, and F441<br>Anticipated Date of Correction: April 21, 2010 |
| 3201.6.5 | **Nursing Administration** | |
| 3201.6.5.6 | **A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F279. | 3201.6.5.6<br>Cross-refer F279<br>Anticipated Date of Correction: April 21, 2010 |
| 3201.6.6 | **Activities** | |
| 3201.6.6.1 | **The nursing facility's activities program shall provide diversified individual activity plans and** | |

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| | **group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each resident.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F248. | 3201.6.6.1<br>Cross-refer F248<br>**Anticipated Date of Correction: April 21, 2010** |
| **3201.6.10** | **Pharmacy Services** | |
| **3201.6.10.1** | **Each nursing facility shall have a consultant pharmacist who shall be responsible for the general supervision of the nursing facility's pharmaceutical services.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F425. | 3201.6.10.1<br>Cross-refer F425<br>**Anticipated Date of Correction: April 21, 2010** |
| **16 Del. C., Chapter 11, Subchapter II, §1121** | **Patient's Rights (1)**<br><br>**Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in** | |

NAME OF FACILITY: Life Care at Lofland Park

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| | **compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.**<br>**This requirement is not met as evidenced by:**<br><br>Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F241. | 16 Del. C., Chapter 11, Subchapter II, 1121<br>Cross-refer F241<br>**Anticipated Date of Correction: April 21, 2010** |
| **16 Del. C., Chapter 11, Subchapter II §1121** | **Patient's Rights (25)**<br><br>**Every patient and resident shall be free to make choices regarding activities, schedules, health care and other aspects of his/her life that are significant to the patient or resident, as long as such choices are consistent with the patient's or resident's interests, assessments and plan of care and do not compromise the health or safety of the individual or other patients or residents within the facility.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross-refer to the CMS 2567-L survey report date completed 3/4/10, F248. | 16 Del. C., Chapter 11, 1121<br>Cross-refer F248<br>**Anticipated Date of Correction: April 21, 2010** |
| **16 Del. C., Chapter 11, Subchap** | **Nursing staffing**<br><br>**(a) Every residential health facility must at all** | |

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| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
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| VII, §1162 | **times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles. Based on observations of staff working in the facility on 03/02/2010 and 03/04/2010, it was determined that the facility failed to ensure that employees wear nametags.**<br>**Findings include:**<br><br>(1) While walking into and out of rooms #115, 117 and 119 on 03/02/10, staff, E12, was observed to be lacking a nametag.<br><br>(2) While assisting E12, to prepare and bathe a resident on 03/04/10, an unknown staff member | **16 Del. C., Chapter 11, Subchapter VII, 1162:**<br>**Anticipated Date of Correction: April 21, 2010**<br><br>No residents are known to be affected by this deficient practice.<br>All residents have the potential to be affected by the same deficient practice.<br>Re-education of staff (all) regarding their requirement to wear a nametag, prominently displaying his or her full name and title as evidenced by a "Memorandum of Accountability" (Attachment DE1162: 1), documented in the personnel record.<br>Audits will be completed daily, beginning on 3/30/2010. Deficiencies discovered at the time of audit will result in corrective action as outlined in the "Memorandum of Accountability".<br>Results of the audit will be submitted to Administrator and the Facility Operations Committee of QA/PI. Further audit necessity will be determined after a 3 month time frame. |

**NAME OF FACILITY:** Life Care at Lofland Park

**DATE SURVEY COMPLETED:** March 4, 2010

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| | also lacked a nametag. E12 was missing a nametag on this occasion as well. | |